TRANSACTIONS OF THE NEW YORK SURGICAL SOCIETY.

Stated Meeting, April 11, 1894.

The President, ROBERT ABBE, M.D., in the Chair.

NEPHRECTOMY SUPPLEMENTING NEPHRO-LITHOTOMY.

DR. CHARLES K. BRIDDON presented a patient, a man, forty-nine years of age, who, from the age of five years, had been the subject of attacks which consisted of excruciating pain referred to the region of the left kidney behind. The pain would begin slowly but would gradually increase in severity until the acme was reached in about ten hours. Then of a sudden the pain would leave him, his bladder would instantly fill up, and he would pass sixteen to eighteen ounces of urine. The relief was almost instantaneous, for in a very few minutes he would feel perfectly well and attend to any duty or engage in any sort of sport. Attacks precisely similar to these in character occurred throughout the patient's life at varying intervals in spite of various methods of treatment. The intervals between the attacks would at times be of several months, at times only of a few weeks, there being no regularity whatever in their occurrence. Between the attacks the patient was always entirely free from pain. He thinks he remembers to have had some blood in his urine once or twice, but is not certain. At the age of forty-five he sought operative treatment. This was four years ago, and a lumbar nephrotomy was then performed upon him in one of the city hospitals. The kidney sac was cut into and its contents evacuated, but no stone was found.

Five weeks after the operation the old pain returned precisely similar in character to that previously suffered. These attacks he has had about every two weeks since then. The wound healed up, but the patient experiences no appreciable benefit from the operation. During these attacks the pain was partially controlled by large doses of morphine. The patient was rather loth to undergo any further

operative procedure, but after a period of six months' trouble this last summer and fall, in which the attacks were frequent and severe, he finally consented to an exploratory operation, by Dr. Briddon, the object of which was to ascertain the condition of the disturbing kidney, with the understanding that it should be removed, should it prove to be diseased or useless.

During his stay in the hospital previous to operation his urine varied in specific gravity from 1015–1024, contained albumen varying from three to twenty per cent., almost constantly some pus,—a few blood-cells being also found once,—in other respects negative.

On January 3, 1894, the kidney was exposed by a vertical lumbar incision. It was surrounded on all sides by dense adhesions,—posteriorly especially they were extremely firm. Sweeping over the anterior surface of the kidney the finger broke through the remaining thin shell of kidney-tissue into a large pus-cavity. In fact, the kidney, as it was, was only a large pus-sac surrounded by a delicate wall of renal tissue. The pus was evacuated. The finger then came into contact with a calculus which, with some other loose fragments, was removed. The remaining mass of renal tissue being useless as a kidney it was decided to remove it. For this a second incision was made, running at right angles to the first from about its middle, allowing more room for manipulation.

The kidney-tissue was then removed piecemeal, a small quantity being left behind, however, to serve as part of the pedicle to be tied off. This was done with heavy silk.

The edges of the gaping wound were approximated somewhat with a few silkworm-gut sutures, the wound itself being packed to its bottom with iodoform gauze. Projecting from the wound were the ligatures around the pedicle, left long purposely. An aseptic dressing was applied and the patient returned to the ward.

Considerable shock attended this operation.

For the first three days following the operation he passed urine to the amounts respectively of sixteen to twenty-six and thirty-nine ounces, the urine containing some albumen, pus, and blood. His thirst was relieved by enemata of water at first, the pain controlled by morphine, and his general condition sustained by liberal stimulation. On the fourth day the wound was dressed, being irrigated with peroxide of hydrogen and 1–5000 corrosive sublimate solution, then repacked lightly with iodoform gauze. The patient complained of more or less pain, but not the same pain as experienced before the operation.

After this the wound was regularly dressed every second day, the healing process progressing favorably. The small bit of tissue, however, between the two horizontal incisions of this operation, and the oblique cicatrix of the previous operation four years ago, did not retain its vitality, its blood-supply being inadequate. The ligatures surrounding the pedicle were slow to cut through. It was not until six weeks after the operation that the first loop came away, the others being removed four days later. After this date his recovery was uneventful. The calculus was composed of urates; it appeared to be formed by the fusion of four distinct masses, measuring three and three-quarters inches in circumference and weighing 100 grains.

NEPHRECTOMY FOR URINARY FISTULA FOLLOWING NEPHROTOMY FOR PYONEPHROSIS.

DR. BRIDDON presented a second patient, a woman, twenty-nine years of age, who had been admitted into the Presbyterian Hospital, September 10, 1893, with pronounced symptoms of pyonephrosis of three months' duration. In her right lumbar region a mass could be made out the size of one's two fists, not connected with the liver above, and tender. A lumbar nephrotomy was done and a pus-sac emptied. Considerable healthy kidney-tissue was found; the kidney was therefore left.

Following this operation the parts all healed with the exception of a small fistulous tract leading into the kidney. Through this a considerable amount of urine was passed daily, the daily amount by the urethra varying from twenty to thirty ounces. She still complained of some pain in the region of the right kidney. As the fistulous tract persisted, in spite of efforts to close it, the removal of the kidney was done, five months after the first operation. The lumbar incision was employed along the outer border of erector spinæ muscle just to the inner side of the fistulous opening. When the kidney was reached its motion up and down with respiration could be plainly seen, amounting to one-half to three-fourths of an inch in extent. Endeavor was made to free the kidney from its surrounding structures without breaking through the capsule. This was found in places to be a difficult matter on account of the adhesions. To allow of more room, a second incision at right angles to the first was made, running anteriorly for about four inches. A silk "loop" was then passed through the kidney-substance, allowing the kidney itself to be brought farther up into the wound for manipulation. The

kidney was finally freed behind. In front its peritoneal investment was also pushed back and the kidney itself brought thoroughly into the wound. Its pedicle, consisting of vessels, ureter, etc., was then tied off with silk, cut, and the kidney removed. The fistulous tract was also removed.

During the operation a part of the posterior surface of the kidney was broken into and some pus came out, which was immediately sponged away. When the pedicle was cut, and, in fact, during the whole operation, the oozing was only slight and easily controlled.

The wound was packed with iodoform gauze, the ligatures around the pedicle being left long and protruding from the wound in the dressings. The patient recovered well from the operation.

For the first week following the operation the daily amounts of urine passed were respectively,—25½ ounces, 1023; 31½ ounces, 1034, the urine containing only a trace of albumen and some few pus-cells; 35 ounces; 23 ounces; 28 ounces, 1025; 32 ounces; and 34 ounces.

The wound was dressed at intervals, being allowed to heal up from the bottom. The pedicle ligatures came away on the fortieth day. By the end of ten days from the operation the urine had run up to forty ounces daily, and has since maintained itself about these figures. The pus disappearing in a few weeks entirely.

The pathologist's report on the kidney removed was that some of the calyces were distended, the walls rough, and the surrounding tissue inflamed and soft. There were a few small yellow nodules resembling tubercles. On microscopic examination the diagnosis of tubercular inflammation was confirmed. When the patient was presented, two months after operation, the wound was almost closed and the patient felt perfectly comfortable. She was passing from forty to fifty ounces of normal urine daily.

COCCYGEAL DERMOID CYST UNDERGOING EPITHELIOMATOUS DEGENERATION.

DR. BRIDDON also presented a man, fifty-two years of age, who, thirty years ago, first noticed a swelling over the coccyx, which, after gradually increasing in size for some time, appeared to ooze out a watery discharge and become smaller; it was never painful, and the occasional increase and diminution in size continued until some months ago, when it became sensitive, prevented him getting about or assuming the sitting posture.

When admitted to the Presbyterian Hospital, immediately over the coccygeal region was an ovoid fluctuant tumor, measuring in its vertical diameter four inches; transverse, two. Skin covering it slightly reddened, while the upper portion contained some very hard masses.

Under ether, the tumor was dissected out from its surroundings. The superficial portion of the cyst-wall was thin and closely related to the skin. The deeper portion, non-adherent, was very much thicker. At the tip of the coccyx a thin-walled process, about one inch and a half in diameter, passed into the pelvic cavity, but was easily shelled out. The integuments were approximated by sutures of silkworm gut, but union *per primam* failed, and the wound is not yet entirely healed.

The cyst was about the size of a goose's egg, an incision giving exit to a few ounces of blood-stained fluid. The superficial walls were thin, the deeper ones in some places three-quarters of an inch thick, and irregularly eroded.

DR. THACHER, the pathologist, reports that the cyst showed connective tissue, containing epitheliomatous alveoli, and that it was probably a dermoid cyst, whose lining had become epitheliomatous.

DR. J. A. WYETH remarked that a man with a dermoid cyst of the coccyx came under his care ten years ago. He was thirty-five years of age. The cyst had never given him any trouble; was supposed to be a fistula, and for which Dr. Wyeth was requested to operate. Instead of a fistula he found a dermoid cyst, which contained a tuft of hair. A case of epithelioma in the same region was sent him subsequently by Dr. Andrew Robinson, and he was of the impression that it had probably resulted from a dermoid cyst of the coccyx, although proof of this was lacking. He excised it freely, but there was recurrence, and he sent the woman back to Dr. Robinson, who used Marsden's paste, and effected a cure. Since this time Dr. Wyeth had used Marsden's paste many times, and would recommend it in Dr. Briddon's case. He used two parts arsenious acid, one of powdered acacia, and added enough cocaine to deaden sensibility. Pain was not complained of.

DR. R. ABBE thought coccygeal cysts were almost always dermoid. He had had three cases during the past five years. He saw no reason why they might not become epitheliomatous, as sometimes occurred in sebaceous cysts of the scalp.

Experience had taught him that it was not best to make a vertical incision along the groove in excising coccygeal cysts, but to cross into the soft fatty tissues and draw to one side. Primary healing would then take place.

DR. W. MEYER had seen a number of cases of cyst of the coccyx, and had been impressed by the readiness with which they took on inflammation. In a large one the presence of fæcal odor led to the supposition that it was a fæcal fistula, but it was found to be only a dermoid cyst which had undergone suppuration. In another case, owing to the hard borders and painful condition, the diagnosis of carbuncle had been erroneously made. When inflammation existed, he packed the wound left after excision with gauze, removed it after three or four days, stitched the edges together, after which there was prompt union.

SIMULTANEOUS LIGATION OF INTERNAL ILIAC ARTERIES FOR HYPERTROPHY OF PROSTATE.

DR. WILLY MEYER presented a patient on whom he had performed Bier's operation for the relief of symptoms attending hypertrophy of the prostate, accompanying the presentation with remarks upon the method. (See page 44.)

DR. WYETH said that while one could but admire the operator's boldness and skill, it seemed to him the operation was rather a formidable one, and the benefit to be derived from it was not commensurate with the danger incurred. Moreover, there was another simple and successful method of relieving the damming in of urine caused by the prostatic enlargement and urethral closure. He referred to suprapubic drainage, a method the success of which had been enhanced by the apparatus devised by Dr. Meyer himself. If continuous suprapubic catheterization were resorted to in the case presented to-night, there would be no necessity for drawing off residual urine, which is now necessary even after so dangerous an operation as he had been subjected to.

DR. BRIDDON acquiesced in the remarks of Dr. Wyeth, for while he felt indebted to Dr. Meyer for bringing the operation to the notice of American surgeons, and admired the boldness displayed in the case presented, yet he would not care to take the risks for the results promised, especially when relief could be obtained with certainty by other means.

DR. KAMMERER thought that suprapubic drainage, to which allu-

sion had been made, had drawbacks. He had been unable to prevent leakage by such apparatus as had thus far been devised. He had even had a plaster mould made of the section of the abdomen and a pad fitted to that, yet after a time the patient would again be troubled by leakage.

DR. ABBE remarked that, according to reports which he had read, the method of Dr. Hunter McGuire had been most successful in preventing leakage in suprapubic drainage. It consisted in conducting the catheter through an oblique channel made by the knife in the walls of the abdomen and allowed to cicatrize.

DR. BRIDDON had performed Dr. McGuire's operation in two cases strictly according to the directions given by the inventor, yet it had not prevented leakage. In his judgment dilatation must necessarily take place in the channel around the tube from pressure, and soon lead to leakage.

DR. MEYER rejoined, saying that suprapubic drainage was only symptomatic treatment, and although he believed leakage could be prevented by the apparatus devised by himself and successfully modified by Dr. Bangs, yet he thought if there was radical cure for the trouble the patient should have the benefit of it. He did not think the operation a very dangerous one, especially if one could simply tie the internal iliacs without cutting the sheath, as he expected to do hereafter.

Replying to an interrogatory by Dr. Wyeth, whether tying the internal iliacs caused atrophy of the bladder by shutting off its circulation, Dr. Meyer said that no such atrophy had occurred in his case or those of Bier's, a fact to be accounted for by the collateral circulation. Regarding artero-sclerosis as a cause of prostatic hypertrophy, none existed in the man presented nor in the patients operated upon by Bier.

Referring to a remark by Dr. Wyeth, he said that his patient did not now have to use the catheter any more, although there was still considerable residual urine.

PAPILLOMA OF THE BLADDER COMBINED WITH STONE.

DR. MEYER presented some specimens, the first being a papillomatous tumor of the bladder of about an apple's size, removed recently by suprapubic cystotomy from a man who had had hæmaturia about twice a year during the past eight years. The sound introduced into the bladder came in contact with a stone. The presence

of the papillomatous tumor was revealed by the cystoscope, its situation being on the left side sufficiently high not to obscure the view of the mouth of the ureter. It was removed on the 27th of December, 1893. The patient made a good recovery. The speaker again emphasized his preference for the transverse incision through the abdominal walls. It was immaterial in which direction the bladder was cut, except that the transverse incision was much easier to close by suture than the longitudinal. In this case he had shelled out the tumor's pedicle with the Paquelin cautery which naturally resulted in traumatic ulcer. The bladder having been sutured, this ulcer produced great spasm, especially when the permanent catheter was removed from the urethra on the fourth day. In his next case of tumor of the bladder, where the insertion of the tumor could not be cut out with the knife within healthy tissue, and the resulting wound in the vesical wall closed by stitches, he would again introduce a suprapubic drain as he had done before, instead of entirely closing the vesical opening.

ENCYSTED VESICAL CALCULUS.

DR. MEYER presented a large vesical calculus obtained in a case which had offered some difficulty in diagnosis. He first saw the patient, a man of seventy-two years, in the fall of 1892, when he was suffering from retention of urine believed to be due to hypertrophy of the prostate. A colleague had tried to introduce a catheter, but had failed. Dr. Meyer found little difficulty in introducing the so-called prostatic catheter-sound of Trendelenburg, and on careful search with that steel instrument found nothing within the bladder. The patient passed from under observation a year, when Dr. Meyer was again called in for retention. The same instrument was used to relieve the patient, but failed to strike anything in the bladder which would lead him to think there was a stone. The patient, who had been a slave of the catheter for three years, was now ordered by his doctor to remain under Dr. Meyer's care. At one of his visits he had complete retention of urine; for the third time Dr. Meyer tried for an hour to enter the bladder, and finally succeeded in Trendelenburg's posture. He decided to make a suprapubic oblique canal, according to Witzel's method for gastrostomy, but before doing so wished to exclude a tumor or calculus, and found himself able to readily pass the irrigating cystoscope in the Trendelenburg posture. He then saw on the "anterior" wall of the bladder a large stone. Being unable

to bring the cystoscope forward, in order to touch the stone, he left it in position and shook the suprapubic region of the abdominal wall, and succeeded in dislodging a large-sized stone out of a position just above the symphysis. On January 30, 1894, it was removed through a suprapubic opening. The wound in the bladder was closed by catgut sutures down to its lower angle, which was left open. Through it a soft rubber catheter was introduced for about two inches. The projecting (outer) portion was then turned down upon the bladder and buried in its wall by stitching over it two folds of the latter, one being taken from each side (infolding). The wound was packed with sterilized gauze. Permanent drainage was applied. Everything went nicely during the first two days. There was no leakage whatever. On the third day the patient had a sudden unexpected stool and pressed the catheter end out of the bladder, no special stitch having been put in in order to fasten it. With some difficulty it was reintroduced in Trendelenburg's posture. Two days later the same accident occurred. The catheter was again introduced. This repeated manipulation spoiled the result for some time. Patient is now cured with a tightly-closing wound around the catheter. He wears a urinal. What had been called McGuire's operation to-night, seemed to be the formation of an oblique canal through the wall of the stomach or bladder. This was originally proposed by Witzel, of Bonn, in 1891.

SARCOMA OF THE KIDNEY.

DR. ABBE presented a kidney which had undergone sarcomatous degeneration. It weighed about a pound and a half, and had been removed the day before from a child three years and a half old. Trendelenburg's posture: long cross incision: minimum loss of blood. The child was doing well.

Stated Meeting, April 24, 1894.

The President, ROBERT ABBE, M.D., in the Chair.

PYLOROPLASTY FOR ULCER OF THE STOMACH.

DR. B. F. CURTIS presented a colored man, sailor, aged thirty-seven, on whom a month before he had performed pyloroplasty for syphilitic (?) stricture of the pylorus. In April, 1893, the man had